Highmark's Weekly Capitol Hill Report

Issues for the week ending November 18, 2022

Federal Issues

Legislative

Congressional Update

Congress came back to Washington for the first time in six weeks and for the first session following the mid-term elections, which yielded Democratic control of the Senate and Republican control of the House, both with the narrowest of majorities.

- **Leadership elections:** Much of the week focused on caucus and chamber leadership dynamics with both House and Senate Republican leaders Kevin McCarthy and Mitch McConnell fending off challenges from fellow Republicans and House Speaker Nancy Pelosi announcing on Thursday that she would no longer lead the caucus in the new Congress. Additionally, the leadership of the Senate HELP Committee was clarified with Sen. Rand Paul announcing he would not take the ranking member role, clearing that path for Sen. Bill Cassidy to become the top HELP Republican in the 118th Congress. Sen. Bernie Sanders will Chair the HELP Committee as current Chair Patty Murray will be taking on leadership of the full Senate Appropriations Committee. On the House side, the chairmanship of the Ways & Means Committee remains to be determined,

In this Issue:

with Rep. Richie Neal remaining as Ranking Member.

- **Lame Duck Session**: The week brought little additional clarity to the contours of the lame duck legislative session. As Congress is back in recess next week for Thanksgiving, we expect more updates on this at the end of November and early December. In addition to the funding the federal government by December 16th, Congress will have to act on several Medicare and FDA extenders that also expire on the 16th and is still wading through a number of other items, including a push to stop planned Medicare cuts to physician payment rates and to extend telehealth flexibilities.

As previously reported, while not necessarily must-dos, **there are several other health care items that could come into play during the lame duck session:**

- Tempering cuts to Medicare providers under the Physician Fee Schedule that are scheduled to go into effect on January 1
- A bipartisan mental health package that has been worked on by multiple House and Senate committees
- Legislation to promote electronic prior authorization in Medicare Advantage
- An extension of telehealth provisions enacted in response to the pandemic
- Legislation supported by dialysis providers that would require parity between ESRD coverage and other chronic conditions

- **CMS Releases Annual Report to Congress on Medicaid Drug Review and Utilization Requirements Under SUPPORT Act**
- **Analysis Released of Litigation on ACA Preventive Services Mandate**

Federal Issues

Regulatory

AHIP Files Amicus Brief Supporting Government's Defense of *No Surprises Act* Regulations

AHIP filed an amicus brief supporting the federal government's continuing effort to implement the *No Surprises Act*. The underlying lawsuits (*Texas Medical Association v. HHS* and *LifeNet v. HHS*) challenge the recent final rule implementing certain requirements for independent dispute resolution entities (IDRE) and what factors they are required to consider when making out-of-network payment determinations. The cases are currently pending in and assigned to the same judge that ruled in two earlier lawsuits filed by the same plaintiffs. Those earlier lawsuits challenged aspects of the agencies' interim final rules, which anchored the IDR process around the "qualifying payment amount" (QPA).

Why this matters: AHIP's brief underscores why the recent guidance is needed to help provide some degree of structure and predictability to an IDR process already experiencing far more claims than the federal government expected. AHIP also highlighted the credibility and importance of the QPA under the new law and the important role it continues to play in the IDR process.

The brief also explains how the recent final rule offers basic, common-sense guidance regarding how IDREs are to consider information relevant to IDR claims. That guidance includes requiring IDREs to rely on relevant, credible, and non-duplicative data submitted by providers when evaluating claims. In addition, AHIP also explained how, if providers' view were to prevail, it would turn the IDR process into an arbitrary free-for-all that would work at odds with the law's intended goal of trying to lower healthcare costs for patients and consumers. Other groups filing amicus briefs in support of the government include the American Benefits Council along with a group of employers and various patient advocacy groups led by the Leukemia & Lymphoma Society.

These latest lawsuits by TMA and LifeNet allege the agencies exceeded their authority and violated the Administrative Procedure Act by arbitrarily and capriciously including provisions in the new final rule that presumptively favor the QPA and otherwise improperly constrain what information IDREs may consider when resolving claims.

Next Steps: Summary judgment briefing is scheduled to conclude on December 7 with a hearing to follow on December 20. Plaintiffs have asked for a decision by the end of January 2023.

CMS Releases Framework for Improving Rural Health Care

In conjunction with National Rural Health Day on November 17, the Centers for Medicare & Medicaid Services (CMS) released a new Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities. The Framework focuses on several areas in which CMS plans to focus over the next 5 years to promote high-quality, equitable care in these communities.

One CMS priority is to expand access to comprehensive health care coverage, benefits, and services and supports. Key activities in the framework include:

- Extending Medicaid and CHIP postpartum coverage to 12 months, maintaining time and distance standards for Medicare Advantage plans, and reducing the number of single-issuer rural counties.
- Addressing social determinants of health (SDOH) risk factors and unmet social needs in rural communities.
- Improving access to long-term services and supports, including through programs such as Medicaid's Money Follows the Person program.
- Continuing to explore opportunities to enhance uptake and coverage of telehealth, broadband access, and other virtual services where appropriate.

CMS also outlined other priorities for advancing rural health outcomes, such as increasing collections and use of standardized data, optimizing medical and communication technology, and driving innovative payment and service delivery models and value-based care.

Section 1557 Ruling Limits Application of Bostock to Health Care Discrimination

A Texas federal judge released an opinion holding that the Supreme Court's landmark 2020 decision in Bostock v. Clayton County is not applicable to the Affordable Care Act's protections against discrimination based on sex in health programs and activities.

The ruling effectively takes away the primary rationale adopted by the Biden Administration for its May 2021 announcement to enforce and interpret Section 1557 to include sexual orientation and gender identity as part of factors protected by the ACA's nondiscrimination provision. Since then, the administration issued proposed regulations reflecting this interpretation, in a reversal from the Trump administration-era Section 1557 regulations which had limited the scope of sex discrimination.

The opinion reasons that the Supreme Court in Bostock explicitly stopped short of stating the opinion applied to statutes beyond the employment context under Title VII of the Civil Rights Act. "Instead, Congress limited Section 1557's protections to those afforded by other federal statutes — including Title IX. Because Title IX does not protect 'sexual orientation' or 'gender identity' status, neither does Section 1557."

Why this matters: The opinion will likely shape the pending final rules that the Department of Health and Human Services is expected to finalize next year.

HHS-OIG Reports on 2022 Top Management & Performance Challenges Facing HHS Emphasizing Cybersecurity

On November 16, the U.S. Department of Health and Human Services' Office of the Inspector General (HHS) published its annual evaluation of how the Department can improve its services and what challenges face the department. In this version, the Office of the Inspector General (OIG) identified six top management and performance challenges (TMCs) that HHS faces in the coming year. **The six challenges are:**

- Safeguarding Public Health,
- Ensuring the Financial Integrity of HHS Programs,
- Delivering Value, Quality, and Improved Outcomes in CMS Programs,

- Safeguarding the Well-Being of HHS Beneficiaries,
- Harnessing and Protecting Data and Technology to Improve the Health and Well-Being of Individuals, and
- Strengthening Coordination for Better Programs and Services.

These evaluations serve to inform the public of how HHS is planning to improve and displays what topics are at the forefront of the Department. Notably, this year's challenges differ from last year's challenges only in one key respect: emphasis on "significant challenges to both protect data and technology from persistent cybersecurity threats and improve how the Department and related entities share large amounts of critical data from disparate sources, including public health data, on an unprecedented scale."

Essential Health Benefits Request for Information Clears OMB

The Biden administration is working on a potential overhaul to the Affordable Care Act's (ACA) essential health benefits standards, one of the key features of the ACA's health reforms.

Background: The ACA standardized 10 categories of health care services that fully insured group and individual market plans must cover, though the details of coverage is largely determined by a state's benchmark. Further, cost-sharing for EHBs must be counted towards an individual's deductible and out-of-pocket limit, which the ACA also caps.

The Biden administration made a few changes in rulemaking this year focused largely on prohibiting substitution of benefits between EHB categories and specifying discriminatory benefit design practices. However, EHB policy has not changed radically since the inception of the Exchanges in 2014.

Why this matters: It is possible that the RFI will explore ways to use EHB policy to advance the Biden administration's health equity agenda through greater emphasis on discriminatory benefit design and practices that might have the effect of maintaining or increasing health disparities or as another lever to guarantee contraceptive coverage. The RFI may also revisit the process states must follow when selecting a new benchmark through changes to solicitation of public comments.

Industry Trends

Policy / Market Trends

Summary Report of 2019 and 2020 Benefit Year Risk Adjustment Data Validation (HHS-RADV) Adjustments to Risk Adjustment Transfers Released

CMS released a summary report on issuers' HHS-Risk Adjustment Data Validation (RADV) adjustments to risk adjustment transfers. CMS used the reissued 2019 benefit year HHS-RADV results and 2020 benefit year HHS-RADV results (released on September 15, 2022) to adjust 2020 benefit year risk adjustment plan liability risk scores, resulting in an adjustment to 2020 benefit year risk adjustment transfer amounts. The report can be found here.

GAO Report Finds Market Enrollment Remained Concentrated Through 2020, With Increases in the Individual and Small Group Markets

A GAO report found that from 2010 through 2018, enrollment in private health insurance plans was concentrated, indicating that a small number of issuers enrolled most of the people in a given market. Specifically, GAO considered a market "concentrated" in a state if three or fewer issuers held at least 80 percent of that market. These findings indicate less competition overall in the market, potentially creating an unfavorable impact on premiums.

The report can be found here.

CMS Releases Annual Report to Congress on Medicaid Drug Review and Utilization Requirements Under SUPPORT Act

The Centers for Medicare & Medicaid Services (CMS) released the Federal Fiscal Year (FFY) 2020 Annual Report to Congress on Medicaid Drug Review and Utilization Requirements Under Section 1004 of the SUPPORT Act concerning implementation of these Medicaid drug utilization review provisions. The report shows that majority of programs have implemented opioid edits and other standards required by the amendments made by the SUPPORT Act or have a plan in place to implement those standards in the near future. Read More

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Analysis Released of Litigation on ACA Preventive Services Mandate

A component of the ACA's preventive services mandate is being challenged by a Texas District Court ruling in *Braidwood Mgmt. Inc. v. Becerra*. The ruling primarily impacts preventive services covered by USPSTF recommendations. Groom Law Group released an analysis of the challenge and its significance.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

Delaware State Legislation: **http://legis.delaware.gov/.**
New York Legislation: **https://nyassembly.gov/leg/**
Pennsylvania Legislation: **www.legis.state.pa.us.**
West Virginia Legislation: **http://www.legis.state.wv.us/**
For copies of congressional bills, access the Thomas website – **http://thomas.loc.gov/.**